Addendum to _____ **'s Plan** Date: _____
(Child's Name)

This is an Addendum page. It is used for Outcomes that are developed outside the regular IFSP meeting. You should be involved in writing these outcomes just as you were at the IFSP meeting. This page outlines your goal for your child and the services that will be provided. These goals will include activities to build language, pre-literacy, and numeracy skills and should be age-appropriate for your child. A signature line is provided for you, for a physician, and for a lead agency representative.

Date of IFSP: _____
Review Date: _____
Service Coordination Agency: _____
Service Coordinator Name:

What do we want to accomplish? (Outcome) Key Word and/or Number:

Early Intervention Service(s) & Payment Source: (Specific to Addendum)	**Who will be involved:** (Discipline/Name/Agency)	*Review Codes 1 = We did it! 2 = Still working on it 3 = Objective Changed 4 = Postponed 5 = Parent declined service 6 = Objective not addressed a. Waiting for placement b. No funding source c. Other

What Steps need to be taken? (List measurable behavioral objectives)	**How will we know when the objective is achieved?** (Measurable evaluation criteria)	**Strategies and Activities**	**Where will this happen?** (Provide justification if not a natural learning environment)	**Method** (Gr./Ind.), **Service Intensity** (Total Min./Month), **Frequency** (How often)	**Duration** (Start/End Date)	**Objective Reviewed?** (*Code/ Date/ /Initials)

Parental Consent for Services

Your signature verifies that you were involved in developing this page. It means that you agree with what it says and that you want these services.

_____ _____
(Signature) and Relationship to the Child (Date)

_____ _____
(Signature) and Relationship to the Child (Date)

When the parent is in attendance and has received a copy of Parent's Rights, this plan serves as prior written notice for evaluation, placement, and/or the provision of listed services.

Physician Signature

The physician signature is required if these are health related services and are billed to Medicaid. The physician's signature certifies that these services are medically necessary.

_____ _____
Physician Signature (*Required for Medicaid reimbursement) (Date)

***Financial Authorization**

I have reviewed and authorize payment for the above listed early intervention services as defined in the Individuals with Disabilities Education Act (IDEA) Reauthorization, Public Law 108-446, Part C

_____ _____
Lead Agency Authorizing Signature (Date)